

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE E. BENEFITS PAYABLE UNDER HEALTH COVERAGES

CHAPTER 1366. BENEFITS RELATED TO FERTILITY AND CHILDBIRTH

SUBCHAPTER A. COVERAGE FOR IN VITRO FERTILIZATION PROCEDURES

Sec. 1366.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that provides benefits for hospital, medical, or surgical expenses incurred as a result of accident or sickness, including a group health insurance policy, health care service contract or plan, or other provision of group health benefits, coverage, or services in this state that is issued, entered into, or provided by:

- (1) an insurer;
- (2) a group hospital service corporation operating under Chapter [842](#);
- (3) a health maintenance organization operating under Chapter [843](#); or
- (4) an employer, multiple employer, union, association, trustee, or other self-funded or self-insured welfare or benefit plan, program, or arrangement.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.002. EXCEPTION. This subchapter does not apply to:

- (1) a credit accident and health insurance policy subject to Chapter [1153](#);
- (2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance before April 1, 1975;
- (3) accident and health coverages that are incidental to any form of a group automobile, casualty, property, workers' compensation, or employers' liability policy approved by the commissioner; or
- (4) any policy or contract of insurance with a state agency, department, or board providing health services:

(A) to eligible individuals under Chapter 32, Human Resources Code; or

(B) under a state plan adopted in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.003. OFFER OF COVERAGE REQUIRED. (a) Subject to this subchapter, an issuer of a group health benefit plan that provides pregnancy-related benefits for individuals covered under the plan shall offer and make available to each holder or sponsor of the plan coverage for services and benefits on an expense incurred, service, or prepaid basis for outpatient expenses that arise from in vitro fertilization procedures.

(b) Benefits for in vitro fertilization procedures required under this section must be provided to the same extent as benefits provided for other pregnancy-related procedures under the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.004. REJECTION OF OFFER. A rejection of an offer under Section 1366.003 to provide coverage for in vitro fertilization procedures must be in writing.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.005. CONDITIONS APPLICABLE TO COVERAGE. The coverage offered under Section 1366.003 is required only if:

(1) the patient for the in vitro fertilization procedure is an individual covered under the group health benefit plan;

(2) the fertilization or attempted fertilization of the patient's oocytes is made only with the sperm of the patient's spouse;

(3) the patient and the patient's spouse have a history of infertility of at least five continuous years' duration or the infertility is associated with:

(A) endometriosis;

(B) exposure in utero to diethylstilbestrol

(DES);

(C) blockage of or surgical removal of one or both fallopian tubes; or

(D) oligospermia;

(4) the patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the group health benefit plan; and

(5) the in vitro fertilization procedures are performed at a medical facility that conforms to the minimal standards for programs of in vitro fertilization adopted by the American Society for Reproductive Medicine.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.006. CERTAIN ISSUERS OF HEALTH BENEFIT PLANS NOT REQUIRED TO OFFER COVERAGE. An insurer, health maintenance organization, or self-insuring employer that is owned by or that is part of an entity, group, or order that is directly affiliated with a bona fide religious denomination that includes as an integral part of its beliefs and practices that in vitro fertilization is contrary to moral principles that the religious denomination considers to be an essential part of its beliefs is not required to offer coverage for in vitro fertilization under Section [1366.003](#).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.007. RULES. The commissioner may adopt rules necessary to administer this subchapter. A rule adopted under this section is subject to notice and hearing as provided by Section [1201.007](#) for a rule adopted under Chapter [1201](#).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER B. MINIMUM INPATIENT STAY FOLLOWING BIRTH OF CHILD AND POSTDELIVERY CARE

Sec. 1366.051. SHORT TITLE. This subchapter may be cited as the Lee Alexandria Hanley Act.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.052. DEFINITIONS. In this subchapter:

(1) "Attending physician" means an obstetrician, pediatrician, or other physician who attends a woman who has given birth to a child or who attends a newborn child.

(2) "Postdelivery care" means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.053. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act;

(ii) an entity not authorized under this code or another insurance law of this state that contracts directly

for health care services on a risk-sharing basis, including a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter [844](#).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.054. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section [1366.053](#).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.055. COVERAGE FOR INPATIENT CARE REQUIRED. (a) Except as provided by Subsection (b), a health benefit plan that

provides maternity benefits, including benefits for childbirth, must provide to a woman who has given birth to a child and the newborn child coverage for inpatient care in a health care facility for not less than:

(1) 48 hours after an uncomplicated vaginal delivery; and

(2) 96 hours after an uncomplicated delivery by cesarean section.

(b) A health benefit plan that provides to a woman who has given birth to a child and the newborn child coverage for in-home postdelivery care is not required to provide the coverage required under Subsection (a) unless:

(1) the attending physician determines that inpatient care is medically necessary; or

(2) the woman requests inpatient care.

(c) For purposes of Subsection (a), the attending physician shall determine whether a delivery is complicated.

(d) This section does not require a woman who is eligible for coverage under a health benefit plan to:

(1) give birth to a child in a hospital or other health care facility; or

(2) remain under inpatient care in a hospital or other health care facility for any fixed term following the birth of a child.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.056. COVERAGE FOR POSTDELIVERY CARE REQUIRED.

(a) If a decision is made to discharge a woman who has given birth to a child or the newborn child from inpatient care before the expiration of the minimum hours of coverage required under Section [1366.055](#)(a), a health benefit plan must provide to the woman and child coverage for timely postdelivery care.

(b) The timeliness of the postdelivery care shall be determined in accordance with recognized medical standards for that care.

(c) The postdelivery care may be provided by a physician, registered nurse, or other appropriate licensed health care

provider.

(d) Subject to Subsection (e), the postdelivery care may be provided at:

- (1) the woman's home;
- (2) a health care provider's office;
- (3) a health care facility; or
- (4) another location determined to be appropriate under rules adopted by the commissioner.

(e) The coverage required under this section must give the woman the option to have the care provided in the woman's home.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.057. PROHIBITED CONDUCT. An issuer of a health benefit plan may not:

(1) modify the terms and conditions of coverage based on a request by an enrollee for less than the minimum coverage required under Section 1366.055(a);

(2) offer to a woman who has given birth to a child a financial incentive or other compensation the receipt of which is contingent on the waiver by the woman of the minimum coverage required under Section 1366.055(a);

(3) refuse to accept a physician's recommendation for inpatient care made in consultation with the woman who has given birth to a child if the period of inpatient care recommended by the physician does not exceed the minimum periods recommended in guidelines for perinatal care developed by:

(A) the American College of Obstetricians and Gynecologists;

(B) the American Academy of Pediatrics; or

(C) another nationally recognized professional association of obstetricians and gynecologists or of pediatricians;

(4) reduce payments or other forms of reimbursement for inpatient care below the usual and customary rate of reimbursement for that care; or

(5) penalize a physician for recommending inpatient care for a woman or the woman's newborn child by:

(A) refusing to permit the physician to participate as a provider in the health benefit plan;

(B) reducing payments made to the physician;

(C) requiring the physician to:

(i) provide additional documentation; or

(ii) undergo additional utilization review; or

(D) imposing other analogous sanctions or disincentives.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.058. NOTICE OF COVERAGE. (a) An issuer of a health benefit plan shall provide to each individual enrolled in the plan written notice of the coverage required under this subchapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1366.059. RULES. The commissioner shall adopt rules necessary to administer this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.